STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place, Metro Center
NASHVILLE, TN 37243
www.tennessee.gov/health

TENNESSEE BOARD OF NURSING

Local (Nashville Calling Area) 615 -532-3202
Nationwide (toll free) 1-800-778-4123, ext. 25166

ADVANCED PRACTICE NURSE CERTIFICATE OF FITNESS TO PRESCRIBE INSTRUCTIONS

It takes approximately 4 weeks for a certificate to be issued. If additional information is required you will be notified by mail. It is not necessary to call the board to check on the status of your application. Go to www.tennessee.gov/health, click on verification.

To apply for state certification, submit the following:

1. **APPLICATION.** Complete **all** sections.

2. **Affix one (1) recent professional passport type (2½" x 2½") photograph.**

a) Vending machines, snapshots or ID photographs are not acceptable.
b) Straight on pose including head and shoulders.
c) Legal signature on front of photograph - signature must not conceal face.

3. **Sign Affidavit at the bottom of page 3 in the presence of a Notary Public.**

4. Attach an official **nursing transcript, conferring advanced nursing practice. (e.g. MSN, Ph.D.) A student issued official transcript is acceptable.**

5. **Attach a copy of current certificate from national certifying body (e.g. ANCC, AANP, AANA).**

6. **Attach Mandatory Practitioner Profile Questionnaire with your application if not currently on file. Form available online**

7. **Copy of current RN license**

8. **CERTIFICATE FEE***

Attach the correct fee in U.S. currency. **Check or money order must be made payable to the TN Board of Nursing**

a.	Certificate Fee	$200.00
b.	State Regulatory Fee	10.00
		$210.00

FEES SUBMITTED TO THE BOARD ARE NOT REFUNDABLE

APPLICATION COMPLETION CHECKLIST:

		YES	NO
1.	Completed application form (notarized) – Advanced Practice Certification	❒	❒
2.	Fee ($210.00)	❒	❒
3.	Passport type photograph – signed on front;	❒	❒
4.	Official advanced practice nursing transcript	❒	❒
5.	Copy of national specialty certification	❒	❒
6.	Mandatory Practitioner Profile Questionnaire attached or on file.	❒	❒
7.	Requested court record records (if applicable).	❒	❒
8.	Copy of current RN license	❒	❒

If you change your address, it is your responsibility to notify this office or go to www.tennessee.gov/health.

If you change your name, you must submit a copy of the legal document that changed your name. Fax to (615) 741-7899.

Please contact the Board if you have not received a certificate within four (4) weeks from the date of application.

Board phone number: 1-800-778-4123 extension 25166; local, 615-532-5166.

PHOTOGRAPH
NOT TO EXCEED
2½" x 2½ "
PASSPORT TYPE

GLUE PHOTOGRAPH HERE
SIGNED ON THE FRONT BY
APPLICANT

Tennessee Board of Nursing
227 French Landing, Suite 300
Heritage Place, Metro Center
Nashville, TN 37243

1702/ 001-$200.00
006-$ 10.00

FEES ARE NOT REFUNDABLE

APPLICATION FOR CERTIFICATE AS AN ADVANCED PRACTICE NURSE

HAVE YOU EVER BEEN LICENSED AS AN ADVANCED NURSE IN TENNESSEE? ❒ YES ❒ NO
IF YES, CONTACT THIS OFFICE FOR A REINSTATEMENT APPLICATION. DO NOT COMPLETE THIS FORM.

TO BE COMPLETED IN INK BY APPLICANT. PLEASE REFER TO INSTRUCTION SHEET WHEN COMPLETING THE APPLICATION PRINT OR TYPE. ALL QUESTIONS MUST BE COMPLETED.

PART 1 PERSONAL INFORMATION

1. Name _____
LAST FIRST MIDDLE MAIDEN

2. List any other names by which you have been known _____
LAST FIRST MIDDLE

3. Address where you want certificate mailed:
_____
(Street/PO Box/Route) (City/State/Zip)

4. Social Security Number_____ Telephone Number _____ _____ _____
HOME OFFICE MOBILE

5. Tennessee RN License Number _____ Date of Birth _____ Gender: ❒ Female ❒ Male
If practicing in Tennessee on the multistate privilege, list state and license number _____

6. Ethnic Group: ❒ White ❒ Black ❒ Native American Indian ❒ Asian ❒ Hispanic ❒ Other, Specify _____

7. **PRIMARY STATE OF RESIDENCE**

I declare that my primary state of residence is _____. This state is referred to as my home state under the Nurse Licensure Compact and means that it is my declared fixed permanent and principle home for legal purposes and is my domicile. **The following items may be requested as proof of primary state of residence: driver's license, voter registration card, federal income tax return.** If you indicated another compact state as your primary state of residence, but will be moving to Tennessee and declaring Tennessee as your primary state of residence please indicate:
YES ❒ and date of move to Tennessee _____

PART 2 ADVANCED PRACTICE NURSE CERTIFICATION INFORMATION

8. **Advanced Practice Nursing Education:**

8.1 _____ 8.2 Degree ❒ Associate ❒ Diploma ❒ Doctorate ❒ Baccalaureate ❒ Masters
Name of College/University/School of Nursing

Location _____
CITY STATE
Length of Program _____ Date of Enrollment _____ Completion Date _____

9. **Disciplinary Action**

9.1 Have you ever had a nursing license (RN or APN) certification or any other professional license, certificate, privilege or registration disciplined (revoked, suspended, placed on probation or reprimanded) or voluntarily surrendered in any state or jurisdiction?
❒ YES ❒ NO

9.2 If **yes**, please identify the state where the action was originally taken _____
State

10. Are you currently in good physical and mental health? (Include any physical or mental limitations) ❒ Yes ❒ No If **no**, please explain: _____

11. **Conviction of a Crime**

11.1 Have you ever been convicted of a misdemeanor or felony other than a minor traffic violation? ❒ Yes ❒ No
If **yes**, please submit a certified copy of the warrant and judgment or conviction papers and evidence of completion of fines, restitution, probation, and a self letter that describes circumstances that resulted in arrest and conviction.

11.2 If **yes**, specify date and type of conviction.

Date _____ Type of Conviction _____
Month/Day/Year

12. What is your activity (practice) status in the nursing profession?
(practice in this profession also includes teaching, administration and research). **Check only one.**

- ❒ = Practicing Nursing full time (1)
- ☐ = Practicing Nursing part time (2)
- ☐ = Not practiced Nursing for less than 2 years (3)
- ☐ = Not practiced Nursing for at least 2 years but less than 5 years (4)
- ☐ = Not practiced Nursing for 5 years or more (5)
- ☐ = Official Use Only (6)

13. Please indicate your major practice area in nursing: **Check Only One**

- ☐ = Community/Public Health (1)
- ☐ = General Practice (2)
- ☐ = Geriatric (3)
- ☐ = Obstetric/Gynecologic (4)
- ☐ = Medical/Surgical (5)
- ☐ = Pediatric (6)
- ☐ = Psychiatric/Mental Health (7)
- ☐ = Critical/Intensive Care (8)
- ☐ = Emergency Service (9)
- ☐ = Case Management (11)
- ☐ = Primary Care (12)
- ☐ = Education (13)
- ☐ = Administrative/Management (14)
- ☐ = Perioperative/Anesthesia (15)
- ☐ = Pain Management
- ☐ = Other, Please Specify (10) _____

14. Please indicate your principal setting of Employment: **Check Only One**

- ☐ = Hospital/Medical Center (1)
- ☐ = Ambulatory/Outpatient Clinic, FreeStanding Surgery Center (2)
- ☐ = Office/Clinic (3)
- ☐ = Nursing Home (4)
- ☐ = Home Health (5)
- ☐ = Private Duty (6)
- ☐ = Insurance (7)
- ☐ = Industrial/Occupational (8)
- ☐ = Community/Public Health (9)
- ☐ = Military/Federal (16)
- ☐ = Hospice (13)
- ☐ = School Nurse (11)
- ☐ = School of Nursing/College/ University (12)
- ☐ = Assisted Living/Home for the Aged (15)
- ☐ = Other, Please specify (10) _____

15. Please indicate your current type of nursing position **Check Only One**

- ☐ = Nurse Anesthetist (Certified) & (17) (Certificate of Fitness to Prescribe)
- ☐ = Nurse Anesthetist (9)
- ☐ = Nurse Practitioner (7)
- ☐ = Nurse Practitioner (Certificate of Fitness to prescribe) (12)
- ☐ = Clinical Specialist (8)
- ☐ = Clinical Specialist (Certificate of Fitness to prescribe) (13)
- ☐ = Nurse Midwife (Certified) (10)
- ☐ = Nurse Midwife (Certificate of Fitness to prescribe) (14)

16. Please indicate your highest degree in nursing: **Check Only One**

- ☐ = Diploma (1)
- ☐ = Associate degree in Nursing (2)
- ☐ = Bachelors in Nursing (3)
- ☐ = Masters in Nursing (4)
- ☐ = Doctorate in Nursing (5)

17. Please indicate your highest degree in another field, if applicable: **Check Only One**

- ☐ = No Other Degree Held (6)
- ☐ = Associate (7)
- ☐ = Bachelors (8)
- ☐ = Masters (9)
- ☐ = Doctorate (10)

AFFIDAVIT

State of _____

County of _____

_____ personally appearing before me, being duly sworn says that _____
NAME OF APPLICANT he/she
is the person referred to in the foregoing application for a certificate to practice as an Advanced Practice Nurse in the State of Tennessee that the statements therein contained are true and that _____ has read and understands this affidavit. **I understand**
he/she
that if the processing of this application is not completed, the application becomes null and void one year from date received. I also understand that falsification of an application is grounds for denial of licensure or discipline against a license.

I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

Legal Signature of Applicant _____

Sworn to before me this _____ day of _____, 20 _____.

Notary Public _____

SEAL

Commission Expires _____

PART 3 ADVANCED PRACTICE CERTIFICATE SPECIALTY PROGRAM INFORMATION

TO BE COMPLETED BY DEAN, DIRECTOR OR CHAIRMAN OF GRADUATE PROGRAM

I hereby certify that _____ was awarded a ❒ Degree ❒ Diploma
Name
in nursing dated _____. The nursing specialty was ❒ Nurse Practitioner ❒ Nurse Anesthetist

❒ Nurse Midwife ❒ Clinical Nurse Specialist.

Signed _____ R.N. Dean/Director

Graduate/Specialty Program _____

Date _____

PART 4 APPLICATION FOR A CERTIFICATE OF FITNESS TO PRESCRIBE AND OR ISSUE LEGEND DRUGS

DO NOT APPLY IF YOU HAVE EVER BEEN ISSUED A TENNESSEE CERTIFICATE OF FITNESS TO PRESCRIBE

TO BE COMPLETED BY DEAN, DIRECTOR OR CHAIRMAN OF GRADUATE PROGRAM

I hereby certify that _____ was awarded a _____
(Name)
Nursing degree dated _____.

The program included three (3) quarter hours of pharmacology or its equivalent. Yes _____ No _____

Signed _____ R.N. Dean/Director

Graduate Program _____

Date _____

DO NOT WRITE BELOW THIS LINE

Name	License Number	Issue Date

JH/G4014056/BN